August 18, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-03-1352-01**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 56 year-old female who sustained a work related injury on ___. The patient was diagnosed with bilateral carpal tunnel syndrome. The patient underwent right carpal tunnel release on 5/3/02. The patient has been treated with post surgical therapy and rehabilitation and pain management. The patient also underwent a left carpal tunnel release. The current diagnoses for this patient include residual pain after carpal tunnel release and neurological deficits after carpal tunnel release.

Requested Services
Chronic Pain Management Program.

Decision
The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 56 year-old female who sustained a work related injury on ___. The ___ physician reviewer also noted that the diagnosis for this patient included bilateral carpal tunnel syndrome. The ___ physician reviewer further noted that the patient underwent sequential carpal tunnel release procedures. The ___ physician reviewer indicated that the patient underwent post surgical therapy and rehabilitation. However, the ___ physician reviewer explained that the patient continues with bilateral wrist pain and on exam has evidence of neurological deficits in both hands. The ___ physician reviewer noted that this patient is under the care of a pain management specialist who has indicated that the patient has exhausted standard treatments for her chronic pain.

The ___ physician reviewer indicated that the patient had undergone a behavioral assessment evaluation that determined the patient has a pain disorder associated with both psychological factors and a general medical condition. The ___ physician reviewer noted that the patient was found to be both anxious and moderately depressed. The ___ physician reviewer explained that the documentation provided does not demonstrate that the patient was treated with a trial of therapy with antidepressant or has undergone any formal evaluation and treatment with a psychologist/psychiatrist. The ___ physician reviewer also explained that the documentation provided does not demonstrate that the patient has undergone repeat nerve conduction studies to establish the results of the surgical procedure. The ___ physician reviewer further explained that the documentation provided does not indicate the treatment modalities, conservative or interventional, that have tried and failed. Therefore, the ___ physician consultant concluded that the requested Chronic Pain Management Program is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of August 2003.